Community Care Program Guidelines for Assistance

Learn more about your options
and apply for assistance

CMH

512 Skyline Boulevard, Cloquet, MN 55720

Updated April 2026

Community Care Program Overview

In alignment with our mission of caring for our neighbors, CMH is committed to providing financial assistance to patients through our Community Care Program.

In accordance with its Community Care Program, Community Memorial Hospital/Raiter Family Clinic will provide uncompensated health care to patients that are determined to be unable to pay for services. This policy shall be applied in accordance with established procedures and no patient shall be denied uncompensated health care based upon race, creed, color, sex, national origin, or any other prejudgment.

All patients who believe they may qualify for financial assistance are encouraged to submit a Community Care Program application.

Eligibility

Only services provided and billed by Community Memorial Hospital/Raiter Family Clinic are eligible for uncompensated care.

Elective services or procedures are not eligible for the Community Care Program.

All inpatient and outpatient accounts are eligible for uncompensated care based on the application requirements. An application must be completed by the patient/guarantor. The application includes:

- Income from all sources for individuals responsible for this obligation, listing gross income for the most recent three-month period (income from seasonal employment will be based on 12 month average).
- Resources from savings and checking accounts, certificates of deposit, stocks, and bonds.
- Number of exemptions as determined by federal income tax laws.
- A copy of the most recent federal income tax return.
- A copy of most recent statements for savings and checking accounts, certificates of deposit, stocks and bond accounts.
- A copy of the letter of denial for Medical Assistance or be currently eligible for Medical Assistance. A facility MNsure Navigator may provide the screening for eligibility.

All third-party resources and non-hospital financial aid programs, including public assistance available through state Medicaid programs, must be exhausted before benefits can be requested.

Deductibles and co-insurance amounts are eligible for benefits if financial circumstances warrant.

Eligibility will be determined by comparing the applicant's income to the Income Eligibility Guidelines (see Figure A).

Figure A

Poverty guidelines published by the U.S. Department of Health and Human Services for calendar year 2026 are as follows:

Number of Family Members	Poverty Guideline	200% of Poverty Guidelines	250% of Poverty Guidelines
1	$15,960	$31,920	$39,900
2	$21,640	$43,280	$54,100
3	$27,320	$54,640	$68,300
4	$33,000	$66,000	$82,500
5	$38,680	$77,360	$96,700
6	$44,360	$88,720	$110,900
7	$50,040	$100,080	$125,100
8	$55,720	$111,440	$139,300
		Patient share 0%	Patient share: Based on a sliding scale

For families with more than eight members, add $5,680 for each additional member. Guidelines are subject to annual review and change.

Program Administration

The Community Care Program will be administered according to the following guidelines:

- The application information will be reviewed and verified by Business Office personnel.
- After reviewing income, Business Office personnel will determine if the patient/guarantor qualifies for assistance based on income and asset guidelines.
- The patient/guarantor will be notified in writing of the eligibility determination.
- Falsification of application or refusal to cooperate will result in a denial.
- The facility reserves the right to change assistance determination if the recipient's financial circumstances have changed.

NOTE: Community Memorial Hospital/Raiter Family Clinic may add criteria of its own to the above, which will allow additional persons to be eligible for uncompensated services.

Excessive medical expenses or other expenses beyond the control of the patient/guarantor would represent acceptable criteria for exceptions to this policy. Such criterion is considered by the facility when in the view of hospital management, payment and/or a deferred payment plan would create undue hardship.

Community Care Program Requirements for Financial Disclosure

The following checklist of requested documents will assist in completing application and meet financial disclosure requirements.

1. Application form

Complete and return

2. Account information

Household family members with CMH/RFC bills

_____

_____

_____

_____

3. Marital status

☐ Single ☐ Married ☐ Divorced

☐ Separated ☐ Widowed

4. Income verification (copies)

☐ All income sources (All family members except under age 18)

- Copies of pay vouchers (Last 3 months)
- Copies of social security payment vouchers or copy of benefit award letter
- Copies of pension payment vouchers

☐ Federal tax return (Most recent signed copy)

☐ W-2's from 2024 (If no tax return)

5. Number of household members reported on tax return

☐ ____

☐ ____ Additional dependents not on tax return

6. Asset verification (Copies)

☐ Checking and savings accounts (Most recent full statements showing deposits and transactions)

☐ CD's (Most recent statement)

☐ 401K/403B and IRA statements

7. Medical assistance letter (copies)

Contact county office to apply for MA

Carlton County - 879-4583

Send determination with application form

☐ Denial letter

☐ Eligibility

- MA # _____

NOTE:

Failure to submit requested information will result in a denial of Community Care assistance.

Community Care Application

Applicant Information

First Name _____ Last Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Home Phone _____

Income	Last 12 months	Last 3 months
Household Gross Wages		
Additional Income		
Total Income		

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer _____

Household members and dependents

☐ Yourself

☐ Spouse, name and employer _____

☐ First names of your dependent children who lived with you _____

_____

☐ First names of your dependent children who do not live with you _____

_____

☐ Other dependents

Name	Relationship	# of months lived in home	Did you provide more than one-half of dependent's support?

Unusual Expenses – Greater than $500

To whom indebted	Type of Acct (Medical, Credit Card, etc.)	Present Balance	Monthly Payment

A separate page may be used for listing of additional unusual expenses.

Certification of Information Provided

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

Date of request _____

Signature of applicant _____

Return completed application and requested information to:

Community Memorial Hospital
Financial Counselor
512 Skyline Blvd.
Cloquet, MN 55720

If you have any questions, please contact our Financial Counselor at 218-499-6721.